ELIGIBILITY ADMINISTRATIVE REVIEW
INSTRUCTIONS AND REQUIREMENTS

There are three steps in the appeal process and information can be found in the Summary Plan Description for your Plan Option. These steps are:

1. Telephone Review
2. Administrative Review
3. Formal Appeal

STEP1 – TELEPHONE REVIEW
Call Member Services and ask for a review within 90 days of the eligibility denial. If you disagree with the results of the review, you may file a written request for an Administrative Review. Contact the Eligibility Unit within 90 days of when the Plan advises you that you request cannot be approved.

Note: Any issue regarding the Plan's eligibility or participation should first be addressed to the Eligibility Unit and then through the Administrative Review process.

STEP II – ADMINISTRATIVE REVIEW
To file a request for Administrative Review, complete all applicable Sections on this form, sign the form and send a copy of the denied action if applicable. Any additional facts or materials that are pertinent to the case should be attached and submitted with this form within 90 days of the denied action concerning your eligibility.

STEP III – FORMAL APPEAL

If your request for Administrative Review is denied, you may file a Formal Appeal, which must be postmarked within 60 days following the date of Administrative Review decision. To file a Formal Appeal, you must complete the applicable form and attach a copy of the decision of the Administrative Review. Instructions are on the Formal Appeal form.

All requests for Administrative Review must be in writing on this specially designed form. If an appeal is received without the corresponding form, it will be returned to you with a copy of the form to complete. Oral requests or oral arguments by telephone or in person will not be considered. An acknowledge letter is sent to you advising of the receipt of your Administrative Review within 72 hours.

Georgia Department of Community Health

ELIGIBILITY ADMINISTRATIVE REVIEW FORM

State Health Benefit Plan
P.O. Box 38342
Atlanta, GA 30334

SECTION I.

Employee Name: _____ SSN: _____

Patient Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ - _____ Work Phone: ( ) _____ - _____

SECTION II.

Describe the reason for your request (attach additional sheets, if needed). Attach any supporting documentation related to the review.

_____

_____

_____

_____

_____

AUTHORIZATION: I hereby authorize the release of any necessary information for the purpose of evaluating this Administrative Review. I understand that the SHBP may contact other entities on my behalf, and I authorize the SHBP to release such information for the purpose of resolving my Administrative Review. The Health Insurance Portability and Accountability Act (HIPAA) requires that the patient authorize this release unless the patient is under the age of 18.

Patient Signature: _____ Date: _____

DCH USE ONLY

Tracking Number: _____

Request Type: ( ) Administrative Review

( ) Non-Appealable